SHERIFFDOM OF GRAMPIAN HIGHLAND AND ISLANDS AT KIRKWALL

[2021] FAI 29

B32/19

DETERMINATION

BY

SHERIFF ANDREW BERRY

UNDER THE INQUIRIES INTO FATAL ACCIDENTS AND SUDDEN DEATHS ETC (SCOTLAND) ACT 2016

into the death of

RODERICK NORMAN MACLEAN

26 April 2021

DETERMINATION

The Sheriff, having considered the information presented at the Inquiry, determines in terms of The Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 ("the Act"):

1. In terms of section 26(2) (a) Roderick Norman MacLean, date of birth 15 November 1978, ordinarily residing in Orkney, died some time after 14.00 on 15 March, 2012 at London Bay, Eday, Orkney.

2. In terms of section 26(2) (b) the incident giving rise to the death occurred while Mr MacLean was diving for scallops from the MV Hildona.

3. In terms of section 26(2) (c) the cause of death is unascertained.

4. In terms of section 26(2) (d) it is not known if the death occurred due to an accident and, if there was an accident, it is not possible to state the circumstances or cause thereof.

5. In terms of section 26(2) (e) there are no known precautions that could reasonably have been taken that might have avoided the death.

6. In terms of section 26(2) (f) it is not known what, if any, defects in a system of working contributed to the death.

7. In terms of section 26(2) (g) there are no other known facts that are relevant to the death

RECOMMENDATIONS

In terms of section 26(1) (b) I have no recommendations to make.

NOTE

INTRODUCTION

[1] This was a mandatory Inquiry as Roderick Norman MacLean was engaged in employment at the time of his death.

[2] Following a number of preliminary hearings the evidence in the Inquiry was heard on 16 and 17 February and submissions on 19 February 2021. It had been intended that the Inquiry take place in May 2020 but there was an unavoidable delay due to the covid pandemic, the closure of the court for some months and the phased reintroduction of business.

[3] The Inquiry was held remotely in view of the necessary restrictions due to the pandemic.

[4] The Crown Office and Procurator Fiscal Office (COPFS) were represented by Fiona Caldwell, Procurator Fiscal, and Shaun Geddes, an interested party, by Clare Connelly, Advocate, instructed by Fiona McDonald, Solicitor.

[5] A total of four joint minutes of agreement and a joint expert forensic report were entered into in advance of the Inquiry and were of great assistance.

[6] So too were affidavits which covered most of the evidence of the witnesses called to the Inquiry.

[7] I heard evidence from Mark Ashton (a forensic pathologist), Mark Pearce and Shaun Geddes as well as three witnesses from The Health and Safety Executive ("HSE") namely William Chilton, Nicholas Bailey and Michael Leaney each of whom had expertise in diving.

THE LEGAL FRAMEWORK

[8] Fatal Accident Inquiries are led by COPFS and presided over by a sheriff.

[9] It is not the purpose of an Inquiry to establish civil or criminal liability.

[10] The Inquiry is held under section 1 of the Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016 (the 2016 Act) and is governed by the Act of Sederunt (Fatal Accident Inquiry Rules) 2017 ("the 2017 rules").

[11] The purpose of such an Inquiry is set out in section 1(3) of the 2016 Act and is to:

(a) establish the circumstances of the death, and;

(b) consider what steps (if any) might be taken to prevent other deaths in similar circumstances.

Section 26 of the 2016 Act includes:

> "(1) As soon as possible after the conclusion of the evidence and submissions in an Inquiry, the sheriff must make a determination setting out –
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> (a) in relation to the death to which the Inquiry relates, the sheriff's findings as to the circumstances mentioned in subsection (2), and
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> (b) such recommendations (if any) as to any of the matters mentioned in subsection (4) as the sheriff considers as appropriate.
>
> (2) The circumstances referred to in subsection 1(a) are -
>
> (a) when and where the death occurred;
>
> (b) when and where any accident resulting in the death occurred;
>
> (c) the cause or causes of the death;
>
> (d) the cause or causes of any accident resulting in the death;
>
> (e) any precautions which –
>
> (i) could reasonably have been taken, and
>
> (ii) had they been taken might realistically have resulted in the death or any accident resulting in the death, being avoided;
>
> (f) any defects in any system of working which contributed to the death or any accident resulting in the death;
>
> (g) any other facts, which are relevant to the circumstances of the death.
>
> (3) For the purposes of subsection 2(e) and (f) it does not matter whether it was foreseeable before the death or accident that the death or accident might occur –
>
> (a) if the precautions were not taken, or;
>
> (b) as the case may be, as a result of the defects.
>
> (4) The matters referred to in subsection 1(b) are –
>
> (a) the taking of reasonable precautions;
>
> (b) the making of improvements to any system of working;
>
> (c) the introduction of a system of working
>
> (d) the taking of any other steps which might realistically prevent other deaths in similar circumstances."

SUMMARY

[12] Roderick Norman MacLean was on board the MV Hildona in the company of Mark Pearce on 15 March 2012.

[13] Shaun Geddes had been due to be one of the party but did not join the others.

[14] On 15 March at London Bay, Eday, Orkney Mr MacLean and Mr Pearce were engaged in diving for scallops with each entering the water alternately and for safe periods of time.

[15] After Mr MacLean surfaced from each of his first and second dives of the day his nose was bleeding, as spoken to by Mr Pearce. Mr MacLean stated that he was able to continue working.

[16] At around 14.00 Mr MacLean entered the water for his third dive of the day. Mr Pearce saw a normal steady stream of bubbles on the surface of the water and after some time a short vigorous release of bubbles lasting for approximately one minute.

[17] Mr MacLean did not surface from this dive.

[18] Emergency services were contacted but the body of Mr MacLean was not discovered until 13 November 2012 and recovered two days later.

[19] A post mortem concluded that the cause of death could not be ascertained.

[20] Enquiries were carried out by The Police Service of Scotland and HSE.

DISCUSSION AND CONCLUSIONS

[21] As the cause of death could not be ascertained it is accordingly not possible to say that it was as the result of an accident.

[22] Consequently, the conclusions I reach are necessarily restricted as it is not possible to say that any defect in working practice, system of work, equipment or otherwise caused or materially contributed to the death.

[23] Equally it is not possible to say what might have been done to prevent the death other than had Mr MacLean not been diving in the course of self-employment.

[24] He was, of course, perfectly entitled to seek to earn a living by diving.

[25] As to Mr MacLean's nose bleeding, according to the agreed medical evidence, this would have been consistent with a condition known as sinus barotrauma. The medical view suggested that Mr MacLean should not have engaged in further diving on the day.

[26] This can be taken to be general advice, with the benefit of hindsight, but there is no evidence that having continued to work that the death was caused, to any extent, by sinus barotrauma or any other medical condition.

[27] The findings I have set out at the beginning of this determination in terms of section 26 of the Act are in keeping with the submissions helpfully stated by Ms Caldwell and Ms Connelly with the exception that Ms Caldwell invited me to make a finding in terms of section 26(2) (g). I have declined to make such a finding but I do deal with the matters she raised in the next paragraph.

ANY OTHER INFORMATION, OBSERVATION OR COMMENT

[28] HSE's enquiries identified certain matters which they concluded were in breach of the Diving at Work Regulations 1997.

[29] The Procurator Fiscal submitted:

a. if the regulations had been followed and if the HSE Commercial Shellfish Guidance had been adhered to, the dive would not have taken place.

b. in particular, due to there being no stand by diver, no attempted rescue was able to be immediately implemented.

c. the guidance was produced due to incidents in commercial scallop diving and reflects the legislation and sets the steps that should have been taken to ensure the safest diving operation.

d. it would be important for all those associated with commercial shellfish diving to be familiar with the terms of HSE publication 'Commercial shellfish diving in inshore water' to aide compliance with the Diving at Work Regulations 1997.

[30] The reason that I have not made a finding in terms of section 26(2) (g) is that it cannot be said that these matters, while relevant to diving in general, are relevant to the circumstances of the death as the cause thereof is not known.

[31] This Inquiry is for the purposes previously set out and is not a more general inquiry into the working practices of those engaged in diving but I do make the observation that full awareness of and careful compliance with the 1997 regulations and the HSE guidance is to be recommended.

[32] I highlight, in particular, that there ought to be a minimum of three divers at each diving operation so that while one is diving, another can enter the water should an unexpected situation arise while the third can remain in charge of the vessel.

[33] Along with Ms Caldwell and Ms Connelly I offer my condolences to the family and friends of Roderick MacLean.